Request to Obtain Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, health information may not be used or disclosed, without authorization, except as provided in the Notice of Privacy Practices. In addition, the policy of Public Health Nursing is to obtain authorization whenever possible. The signature on this form indicates that the named client is giving permission for disclosure(s) of protected health information described below.

AUTHORIZATION SECTION		
Client's Name:	Birth Date:	:/
1. I authorize to release information concerning the a	above referenced client to:	(name and address of provider)
Public Health Agency:Street/Mailing Address:		
City:	State:	Zip:
2. Information authorized to be release	ed is as follows:	
All care given □		
-OR-		
Only care received between (d	ates):to)
-OR-		
The following specific information	ation:	
3. I understand that I have the right to to this authorization.	inspect and to obtain a copy of	of any information disclosed pursuant
Signature of Client or Legal Represent	ative:	Date:
Relationship to Client:		
Signature of Witness:		Date: